



Dependent Care FSA Expense Documentation



Name _____ Last 4 digits of SS# _____
Mailing Address _____
City, State, ZIP _____ Is this a new address? ☐ YES ☐ NO
Daytime Phone Number _____ Email Address _____

Dependent Name _____ Dependent Age _____
Provider Name _____ Federal Tax ID _____
Provider Address _____

Payment Amount \$ _____ Service Start Date _____
Number of Payments _____ Service End Date _____
Total Paid to Provider \$ _____ **Note:** You can claim the total expenses you plan to pay this plan year with appropriate documentation.

Submit this form and documentation to:

Fax (904) 880-2830
Mail BenefitsWorkshop
P.O. Box 56828
Jacksonville, FL 32241

Questions? Contact us!

Email info@benefitsworkshop.com
Phone (888) 537-3539
Website www.benefitsworkshop.com/wellington

IMPORTANT: Documentation Requirements

Forms must be signed by the participant. All forms must be accompanied by valid receipts or a provider's signature. To claim expenses not yet paid to the provider, either have the provider sign this form or provide a service contract.

By signing below, you certify that the payment amount and service dates are accurate and both the participant and provider will notify BenefitsWorkshop if circumstances alter the payment amounts and/or dates of service.

Provider Signature

Date

Participant Signature

Date